CONFIDENTIAL - *(This form must be accompanied by a Medical Release signed by the employee)*

State of Michigan
Work Assessment

HEALTH CARE PROVIDER: Please complete this form (*for physical illnesses/injuries only*) unless the employee/patient is confined to bed rest, is contagious, or hospitalized. The State of Michigan is committed to returning employees to a safe and appropriate work environment. This form provides necessary information to allow the employee to participate in the state's return to work program and enables program staff to identify and locate appropriate work within the employee's abilities. Your assistance is greatly appreciated.

Section I ***Employee/Patient Information***			
Last Name First Name		Social Security Number - -	Date of injury/illness / /
Street Address/Apt. #	City	State	Zip
Department	Work Location	Occupation	Last day worked / /

Section II ***Functional Assessment - Please check the box that indicates the patient's ability to tolerate the following activities or physical demands.***

1. Physical demands - Stamina (total hours *at one time*)

	0	1	2	3	4	5	6	7	8
a. Sit									
b. Stand									
c. Walk									

2. Total hours during eight hour *entire* day

0-2	2-4	4-8

Comments: (ex. Patient should be able to stand or sit at will, or Patient needs to sit down every …)

3. Please specify an N, S, O, F, or C to indicate the extent that the patient can engage in the activities listed below. Where provided, please circle whether the restriction applies to the left, right or both hands/arms:

(N) Never 0% **(S) Seldom 1-6%** **(O) Occasionally 7-33%** **(F) Frequently 34-66%** **(C) Constantly 67-100%**

Activity	Frequency	Activity	Frequency
a. Climb Ladder		b. Stooping	
c. Climb Stairs		d. Bending at waist	
e. Crouch		f. Twist back	
g. Kneel		h. Twist neck/move head	
i. Light gripping/grasping (Left, Right, Both)		j. Drive motor vehicle	
k. Power gripping/grasping (Left, Right, Both)		l. Ride in motor vehicle	
m. Keyboarding (Left, Right, Both)		n. Operate heavy machinery	
o. Reach above shoulder (Left, Right, Both)		p. Use power tools	
q. Reach below shoulder (Left, Right, Both)		r. Perform high speed tasks	

Comments

4. Using the abbreviations N S O F C for the above frequency indicators in #3, indicate below to what extent the patient can engage in the following activities.

Activity	1 - 5 Lbs.	1-10 Lbs.	1-25 Lbs.	1-50 Lbs.	Over 50 Lbs.
a. Carry (Left, Right, Both)					
b. Lift Above Shoulder (Left, Right, Both)					
c. Lift – Thigh to Shoulder (Left, Right, Both)					
d. Lift – Floor to Thigh (Left, Right, Both)					
e. Push (Left, Right, Both)					
f. Pull (Left, Right, Both)					

Comments

Section III Environmental Conditions

EMPLOYEE/PATIENT NAME:

Please indicate specific environmental conditions that the patient should avoid such as humidity, noise, vibration, temperature extremes, etc.

Section IV Sensory Limitations - Please describe Limitations

1. Voice
2. Eyesight (Depth Perception, Peripheral Vision, Color, etc.)
3. Hearing
4. Balance
5. Smell
6. Feeling/Touch
7. Coordination (Hand/Eye, Motor, etc.)

Section V Prognosis/Other Information

1. Is patient likely to improve? ☐ NO ☐ YES If yes, please estimate the expected length of patient's recovery period. Comments

2. Is surgery scheduled? ☐ NO ☐ YES If yes, date of surgery _____

3. Is patient taking prescribed medications? ☐ NO ☐ YES

4. If yes, what impact, if any, does the medication have on the patient's functional abilities at work?

5. Can you suggest accommodations that would assist the patient/employee in returning to work?

6. When will the patient/employee's physical abilities be re-evaluated?

Section VI Health Provider Information

Printed Name of Treatment Provider	Telephone Number ( ) -	Today's Date / /
Street Address/Ste. Apt. #	City State	Zip Code
Provider Signature	Degree(s)/Specialties	

Please ***fax*** this form to: Citizen's Management, Inc. FAX: 517-540-3100